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ABSTRACT

This document is a summary of the comprehensive final report, "A National Survey of the Parent-Child Center Program" (PS 004 505). The survey is a description and analysis of the development and status of the first year's operation of Head Start's Parent-Child Center (PCC) program. The sectional headings denote the scope of the report: (1) History and Organizational Plan of the Parent and Child Centers; (2) PCC Families; (3) Center Facilities; (4) Health Services; (5) Programs for Children; (6) Programs for Parents and Family Members; (7) Personnel Practices; (8) Impact of PCC Program on Children, Families and Communities; (9) Cost Analysis; and (10) Lessons from the First Year. The extensive tables, graphs, and references available in the comprehensive report are not included in this summary. (AJ)

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REVIEW AND SUMMARY

of a

NATIONAL SURVEY OF THE PARENT-CHILD CENTER PROGRAM

Prepared for the

Office of Child Development

U.S. Department of Health, Education and Welfare

August 1970

by

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with

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The organization and focus of this report as well as the implications drawn from the data are the responsibility of the writer and do not necessarily reflect the views of any federal agency, or of Kirschner Associates who authored the National Survey report.

FOREWORD

The Office of Economic Opportunity contracted with Kirschner Associates, Inc. to study the first year of operation of the Parent and Child Centers. Under the general supervision of a Federal Inter-Agency Monitoring Committee (made up of representatives from the larger Sub-Committee on Research and Evaluation), the contractor had the responsibility for developing the national reporting system as well as carrying out a descriptive assessment of the program.

Guidelines for Evaluation (national and local) during the first operating year of the Parent and Child Center Program were developed by the Inter-Agency Sub-Committee on Research and Evaluation, one of five Inter-Agency Sub-Committees involved in the establishment of the PCCs as a federal program. In developing the design for the evaluation plan of the Parent and Child Centers, the sub-committee took into consideration the following assumptions about the first year.

- Each PCC was encouraged to develop its own pattern. Each was also encouraged to draw upon findings of research and use applicable segments of early childhood demonstration programs. Substantial efforts were made to acquaint PCC planners and Directors with earlier programs and research findings, for use in developing program models appropriate to the needs in their areas. Actual programs were left to the discretion of the individual PCCs.

- Collaboration with and coordination by and of community agencies and resources were to be an important ingredient in PCC programs--unlike most existing programs for very young children.

- Involvement of parents and other family members was required ingredient in PCC programs.

- This was to be a service program, in which research was handmaiden to service rather than vice versa, and any conflicts of purpose were to be resolved in favor of service.

- The "experimental" aspects of the program were to be innovations in content and delivery of service, not experimental research.

The first phase of the evaluation plan called for the development of a national reporting system; the collection of baseline data descriptive of the clientele (children and families being served) and analytical descriptive data on individual program components (services developed and provided). Baseline data describing the children and their families were to be obtained from forms developed as part of a national reporting system, and from standardized psychological test measures utilized on a

sub-sample of children. Analytical descriptive data were to be obtained from systematic observations and interviews by skilled research personnel.

The first year's study was designed to be one means of assessing the service potential of the centers toward reaching their objectives. It was expected that centers would need at least a year for a program "to get off the ground" and during this time, centers needed flexibility for evolving and modifying procedures and program elements without effecting changes in the evaluation design. Further, models of program components in the PCC's were not predetermined; rather the centers were to be free to select and evolve their own. Successive evaluation phases were to be geared toward reporting the advances made by individual centers or types of centers toward their stated objectives, reporting on the effectiveness of different components and combinations of services for different kinds of families in different kinds of communities.

Kirschner Associates, Inc. in preparing a report on the first year of operation relied essentially on three sources of information:

- data from the national reporting system which included basic information on child and family enrollment and characteristics, and turnover; health status of focal children; medical contact records for family members; staff member characteristics and turnover; center goals and policies; activities planned for and provided; and costs.

- reports from 39 Field Research Associates who were to devote an average of 100 hours to each center. These professional research observers visited the centers. Each had a common list of topics and were encouraged to include their personal commentaries and recommendations in their reports.

- a test-retest assessment of infant development on a sub-sample of children in six centers, employing the Bayley Scales of Infant Development.

The problems encountered in the development of the national reporting system and collection of the data are included in the main report. Essentially, data were collected from July 1968 through December 1, 1969. As the starting dates for center operations and services to families differed, data were collected for over one year on some centers and less than one year for others. At the time of this report, centers on the average had been serving families for 12.1 month.

The study of the first year of operation for the 36 Parent and Child Centers required two years and Kirschner Associates, Inc. submitted their report in March 1970. The Inter-Agency Monitoring Committee for PCC Evaluation suggested that a child development specialist, not

associated with the Parent and Child Centers, prepare a summary of the study. We were asked to undertake this task. The Summary which follows has been prepared essentially from the final report submitted by Kirschner Associates, Inc. A National Survey of the Parent-Child Center Program; narrative reports prepared by Kirschner Field Research Associates; a review of administrative records, and communications with staff of the Office of Child Development.

Acknowledgements

In May of 1970, Dr. Charles Gershenson and Mrs. Franc Balzer of the Office of Child Development asked me to review A National Survey of the Parent-Child Center Program and to write a short summary of that report. Reading, thinking about, and writing about the Parent-Child Centers has been a rewarding challenge. I am grateful to them for the opportunity to prepare this material, a task in which I was ably assisted and supported by Miss Ellie Binstock and Mrs. Bettye Wharton.

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HISTORY AND ORGANIZATIONAL PLAN OF THE PARENT AND CHILD CENTERS

HEW Task Force on Early Childhood Development

The welfare of children in this country has long been of vital concern to many individuals, organizations, and governmental agencies. More recently, as the result of meetings with representative organizations and professionals concerned with early childhood education, Secretary Gardner, in 1966, requested the establishment of a Task Force on Early Childhood Development, composed of representatives from the various agencies within the Department of Health, Education, and Welfare. The purposes of this Task Force were to review the goals of the Department relating to child development, to focus on the needs of young children, and to develop recommendations for actions to be taken on behalf of children. The Task Force was co-chaired by Dr. Charles P. Gershenson of the Children's Bureau, and Dr. Minnie P. Berson of the Office of Education. Other members included: Dr. Michael Fischman, National Institute of Child Health and Human Development; Mr. Martin Spickler, Office of Education; Miss Gertrude Hoffman, Children's Bureau; Dr. Dwayne Gardner, Office of Education; Miss Elizabeth Herzog, Children's Bureau; Miss Corrine Kass, Office of Education; and Dr. Caroline Chandler, National Institute of Mental Health. As a result of intensive meetings held in August and September of 1966, a report was prepared entitled Life Line for Children. This report outlining needed services for children, was made available to the then convening White House Task Force on Early Childhood.

White House Task Force on Early Childhood

In the fall of 1966 a White House Task Force on Early Childhood was convened at the request of President Lyndon B. Johnson. This group was made up of acknowledged experts in the field of early childhood drawn from across the country and had the assignment of reviewing the field and making recommendations concerning it. The Task Force was chaired by Dr. J. McVicker Hunt of the University of Illinois and members included: Dr. Urie Bronfenbrenner, Cornell University; Dr. Jerome Bruner, Harvard University; Dr. Marie Costello, Health and Welfare Council, Philadelphia; Dr. Robert E. Cooke, Johns Hopkins University Hospital; Dr. Edmond Gordon, Yeshiva University; Dr. Susan Gray, George Peabody College; Dr. Nicholas Hobbs, George Peabody College; Dr. Lois Murphy, the Menninger Clinic, Topeka; Mr. Joseph Reid, Child Welfare League of America; Dr. Halbert Robinson, University of North Carolina; Dr. George Tarjan, University of California at Los Angeles; Dr. Reginald Lourie, Children's Hospital of Washington, D. C.; and special consultants, Dr. Oscar Lewis, University of Illinois; Dr. John Henry Fischer, Columbia University; Mr. Harold Howe, U. S. Commissioner of Education; Mr. Lisle Carter, Assistant Secretary for Planning, HEW; Dr. Charles P. Gershenson, Director of Research,

Children's Bureau; Mr. Jule Sugarman, Associate Director, Project Head Start. Staff was recruited from government agencies concerned with early developmental needs of children and included Dr. Minnie P. Berson, Office of Education; Dr. Leon Yarrow, National Institute of Child Health and Human Development; Mrs. Franc Balzer, Project Head Start; and Mrs. Clementine Brown as secretary to the Task Force. Work-group sessions were held between September and December of 1966, and at the conclusion of these sessions a final report entitled A Bill of Rights for Children was submitted to the White House.

In February 1967, as a direct result of recommendations made by the White House Task Force, the President delivered a special message to Congress on Children and Youth. He requested the development of 25 comprehensive service programs for families with children under three years of age to be called the Parent and Child Centers (PCC's). A final report prepared by the HEW Task Force in January 1967 entitled Life Line for Children: A Proposal for a Consortium on Behalf of Children encompassing the concept of a new program for children and a new organizational structure for its implementation (the Consortium) was to play a major role in the establishment of the Parent and Child Centers as a federal program, its guidelines, and criteria.

Organization of the Parent Child Centers Program

The Parent-Child Centers Program was established within Head Start, in the Office of Economic Opportunity (OEO) and directed by three members of the Washington Head Start staff. The federal budget provided a $10,000 planning grant for each selected community and a grant of $175,000 for the first year of center operations. Each center was to serve a maximum of 100 children under three years of age and their families.

Criteria for PCC Proposals. The first year proposals included commitments from various community resources for support services as well as center plans for new services. Proposals were required to meet the following eight criteria:

1. Outreach recruitment and admissions procedures which would guarantee that selected families were economically disadvantaged.

2. Comprehensive health care for children, health care and health education for parents and siblings, family planning services, and prenatal care.

3. Children's programs designed to facilitate physical, intellectual, and emotional development.

4. Parent activities designed to strengthen:
   (a) Understanding of child development,
   (b) Competence as family managers,
   (c) Skills essential to making a living, including maximum opportunities for PCC employment,
   (d) Self-confidence and self-image as parents,
   (e) Family relationships, i.e. husband-wife, parent-child,
   (f) Role of the father within the family.

5. Social services for the entire family.

6. Programs designed to increase family participation in the neighborhood and the community in terms of:

   (a) Becoming knowledgeable about its resources and taking advantage of available opportunities,
   (b) Stimulating the family to become participating, responsible, and active members of the community.

7. Training program for both professionals and paraprofessionals, which must include the recruitment and training of neighborhood recruits and volunteers of many age groups to work alongside the professional staff.

8. A Program of research and evaluation developed in cooperation with an appropriate institution such as a University or a Clinic and designed to describe and measure the progress of the programs for children, parents and other family members; as well as program contents and costs. It was also to produce packaged instructional materials and handbooks on how to operate the program. (It was expected that each center's research and evaluation program would be related to a comprehensive research and evaluation plan prepared by a subcommittee organized by Office of Economic Opportunity; Department of Health, Education, and Welfare; Department of Labor; Department of Housing and Urban Development; and the Bureau of the Budget.)

The following were recurring problems which arose in the proposal - funding process:

1. Some communities did not have the local medical, professional, social service, or welfare resources to support a comprehensive PCC program.

2. Some of the target areas selected did not seem to have a sufficient number of eligible families in the communities originally chosen.

3. Bureaucratic delays in large cities were common. Large and complex urban machinery increased the number of levels for negotiation, and fostered delays. Proposal criteria required a high degree of coordination between administrative services (fiscal, personnel, space) and local resources (medical, educational, licensing, etc.)

4. Neighborhood Services Programs (NSP's) were to provide three main core services: administration; health services; and social services. In many cases, PCC's were ready for operation long before NSP's and the plan for NSP's to facilitate PCC operations was not realized.

5. The first year grant of $175,000 was to be matched with a 20 percent local contribution. Funds could not be released until communities met this criterion, or gave indications of being able to meet it in the future.

Release of Funds. According to national office records, 31 of the 36 centers had been funded by June 30, 1968 and four more were funded between August 1968 and June 1969. The thirty-sixth center (Dallas, Texas) was not funded as of December 1969, the closing date of the survey. The average time between release of the operating grant and initial delivery of services to children and families was about four to five months, with a range of three weeks to eleven months.

Sites Established. Thirty-six (36) sites were established in 30 states in collaboration with Community Action Agencies. Thirty-five (35) grants were made, including one Title III migrant grantee, two Boards of Education and 32 Community Action Agencies. The two Boards of Education and 11 Community Action Agencies delegated responsibility for PCC's to Neighborhood Services Programs. Dallas, the thirty-sixth (not yet funded) center, was also to be delegated to an NSP. The sites are listed below, alphabetically by State.

Urban Sites Delegated to NSP's:

Oakland, California
Washington, D. C.
Jacksonville, Florida
Chicago, Illinois
Louisville, Kentucky
Boston, Massachusetts
Detroit, Michigan
Minneapolis, Minnesota
St. Louis, Missouri
New York, New York
Cincinnati, Ohio
Philadelphia, Pennsylvania
Dallas, Texas (not operational by 12/69)
Chattanooga, Tennessee

Other Urban Sites:

Birmingham, Alabama
Los Angeles, California
Atlanta, Georgia
Honolulu, Hawaii
New Orleans, Louisiana
Baltimore, Maryland
Omaha, Nebraska
Newark, New Jersey
Cleveland, Ohio
Portland, Oregon
Houston, Texas

Rural Sites:

Hoonah and Kotzebue, Alaska (villages)
LaJunta, Colorado
Dalton-Summerville, Georgia
Hardinsburg, Kentucky
Pine Ridge, So. Dakota (Indian Reservation)
Fayetteville, Tennessee
Barton, Vermont
Pasco, Washington (Migrant Camp)
Huntington, West Virginia
Menomonie, Wisconsin

Administration of Centers

At the local level, each PCC had a Planning Committee composed of approximately one-third families who would have children enrolled in the program; one-third community representatives; and one-third professionals in disciplines related to young children and family life. This body was to subsequently become the permanent Policy Advisory Committee (PAC), where it was required to draw a minimum of fifty percent of its members from parents enrolled in the program with the remainder consisting of community and professional representatives. Although centers were required to have functional PAC's in order to be eligible for federal funding, in practice the first year for most PAC's was one of turmoil. By December 1969, only 11 centers had PAC's which actively assumed responsibility for center operations.

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PAC's averaged 22 members, although some had as many as 40 members. The more effective committees were the smaller ones. Although parents' recommendations for programs did not differ remarkably from those of staff, their participation in planning had a beneficial effect on programs, in the opinion of observers. Although PCC's were never planned as day care centers for working mothers, the PAC parents emphasized the need for such services in most target areas.

While PAC's were to work together with center directors in planning and supervising program operations, the prescribed autonomy of the centers in relation to the Community Action Agencies was problematic. The federal guidelines assumed that for each center, (1) there would be a stable, fiscally responsible PAC, (2) the CAA would relinquish to the center those functions and powers they retained in other OEO programs, and (3) OEO would

be able to negotiate differences if they arose. Experience has indicated that these assumptions require time to materialize since they involve complex issues, and depend on achieving a balance between flexibility and accountability. Most CAA's wanted control over staff selection, purchases, and payments for medical and dental services. Conflicts around selection and control of professional staff, especially directors, may well have contributed more than any other factor to the problems faced by PCC's during their first year. While OEO staff were able to resolve some disputes, in others they had minimal success. Some directors eliminated the source of power-conflicts by cooperating and not challenging the issue of decision-making powers and they found themselves relatively free to do as they wished. Their experiences demonstrated that complexity and confusion were more responsible than malice for PCC-CAA conflicts which interferred with efficient delivery of services.

Consultation and Evaluation

Project Advisers. Project Advisers who were responsible to the Washington Coordinators were available to the Centers four days a month through a consultative arrangement. Many not only helped to develop the initial PCC proposals but remained as program consultants. Project Advisers were selected from some of the best Head Start consultants so they could bring professional wisdom as well as real experience to the PCC Program. Their effectiveness depended on two primary factors: (1) their comfort and experience in relating to paraprofessional staff and parents, and (2) the amount of practical assistance they could offer in planning programs for young children.

University Affiliates. Each PCC entered a cooperative relationship with a university (or other institution) to arrange for ongoing program evaluation. The university person was to keep a log of operations, with formal research delayed until the second operational year. Only five percent of the budget (approximately $8,750) was allocated for evaluation. The vagueness of their roles, the delays in getting programs underway, and conflicts about research involvement at some centers discouraged many of the university affiliates. As a consequence, there was quite an unevenness in local evaluations. For some centers, the narrative reports of Kirschner's field observers are the closest approximation to a "log of operations."

PCC FAMILIES

The PCC's served very poor families who varied considerably. As a consequence the descriptions of families provided here are illustrative rather than "typical" of any center. One reporter summed it up as follows:

> By and large, the PCC families are the back-alley, side-street residents whose presence the larger community would like to ignore. They are that strange and baffling American phenomenon, the hard-core, depressed poor who as fourth and fifth generation Americans belong to families that have accumulated neither property, education, nor the means for making a livable family income. The men hunt and fish, sleep around the house during the day, and drink with one another at night, work now and again at odd jobs but never seem to develop the skills currently valued and rewarded by society. The women are sickly, overburdened with children and condemned to live as prisoners in squalid, isolated shacks. The mothers and children are dirty, unkempt, ill-nourished physically and intellectually, and the schools send the children out into society as semiliterate, unskilled citizens destined to become tomorrow's welfare recipients.

Number of Families Served

A total of 1,818 families, 2,585 children and 10,417 individuals were being served by 34 PCC's in December 1969. Centers averaged 54 families, 76 focal children and 306 individuals. The number of families enrolled fell below expectations in some cases. (See Table, p. 8) The most frequent explanation was lack of adequate physical facilities to accommodate infants and toddlers. Plans varied according to the purpose of a given center. Although there was no shortage of poor families in most PCC areas, there were numerous problems associated with enrolling and sustaining the involvement of the poorest, who were a major concern of most centers. For example, in one rural area, the families were so isolated and suspicious that numerous visits and much patience were required before a family would enroll, e.g.:

> It was not unusual for the children to hide under the bed or for the mother to fail to answer the door either out of shyness or fear that it was a welfare worker wanting to take her children away from her.

TABLE 1

Number of Months Families Enrolled and Number of Families Enrolled

(December 1, 1969)

Number of Months Centers have provided services to families		Number of Families Currently Served	Total Number of Families Enrolled to Date
4-6 months	3	102	103
7-9 months	4	243	257
10-12 months	6	342	464
13-15 months	16	862	1177
16+ months	5	269	425
Total	34	1818	2426
		Average per center	
12.1 months		54 families	71 families

Delays in funding and bringing programs into the operational stage accounted for some losses, since some families had moved, been routed by urban renewal, or no longer had a child under three years. A plan for families to recruit other families met with little success since the most needy families were also the most frightened, reluctant and socially isolated. One-half to all of the families in 24 of the centers were recruited by door-to-door canvassing.

Housing

Reports from research observers were particularly vivid, especially for rural areas. There were many families living without running water, indoor plumbing, or heat. In one area, there was no running water at all during the winter when the streams were frozen. Thirty-nine percent of the families lived in public housing, and despite the improvements such housing offered, there were reports of children falling to their deaths from the balconies, and a general sense of powerlessness in the face of a complicated and impersonal housing bureaucracy. Some excerpts of housing reports follow:

> Mrs. M lives in a ruin of a house amid ruins of other houses. The house next door is empty, all of the doors and windows are smashed in, and it leans ominously in the direction of the M. home...the aides reported...a sewer broken and water running under the house, a family of eight living in two rooms with no sink, drain or refrigerator. Another family with ten children had no water at all, and there was question about use of the right of way to water coming from a spring. A family was living in a place full of holes, with poor heat; kids were shooting rats with a BB gun. The house, a tar paper shack on bricks, was on the edge of a stream. Two sick looking children were throwing pebbles into the water while their mother boiled the laundry in a tub in the yard. The grandmother sat on a stool nearby.

Characteristics of Families

Poor families are extremely heterogeneous in their characteristics. Aside from sharing a common burden of poverty and a child under three years, there was little else that was similar in the life conditions, styles, problems, or strengths of Black urban mothers, White urban or rural mothers, Indian mothers, mothers in Hoonah, Alaska, or those in Honolulu. Centers varied in their selection procedures, thus some reported only 20 percent while others reported 91% of fathers present. Overall, 58 percent of PCC families had fathers in their homes. Only six families reported absence of a mother. The average family had 5.7 members and 3.6 children, of whom 1.4 were under three years. Rural families were usually larger than their urban counterparts. One in five

families was an "extended" family. Of 958 people in the 364 extended families, female relatives predominated. Grandmothers and/or grandfathers were present in one of five extended family homes. Presumably some of the extended family members represented psychological husbands and fathers.

Age and Education of Parents. One of every five PCC mothers was under 21 and less than one of four was over 35 years of age. Fathers, when present, were usually older than mothers. In spite of their relative youth and the presumed availability of educational opportunity, only 22 percent of parents had completed high school. Of even greater significance was the finding that 39 percent of fathers and 28 percent of mothers had an eighth grade education or less. Four percent had some college credits. Black urban parents had the most education. American Indian and Mexican-American parents had the least education.

Income and Employment. Of the two-thirds of the families who provided this information, 41 percent reported incomes under $3,000 a year; 28 percent between $3,000 and $5,000; 12 percent between $5,000 and $8,000; and only two percent over $8,000. The average per capita annual income was $417. There were a number of difficulties in reporting income data to the contractors, and while they varied, the following were typical:

1. Young mothers living in their parents' homes did not know the family income.

2. Multi-source income, particularly in rural areas, presented calculation problems, and was not easily computed.

3. In most urban centers, enormous hostility was expressed since people felt their poverty was evident and didn't need to be validated.

4. Some people were afraid of welfare officials.

Forty-two percent of all PCC families reported that they were receiving welfare benefits during the first year of operation. The percent of families on welfare ranged from 5% in one center to 84% in another. One-third of rural families and half of urban families received welfare funds. Fathers were reported in the homes of 1,057 families, and of these three-fourths were employed. Of the unemployed, more than a third said they could not find work, and about a fourth reported poor health. Few indicated lack of interest in employment. The highest rates of unemployment were reported for Appalachians and American Indians. In two centers serving these populations, more than half the fathers were without work. There were also four urban centers where more than one-third were unemployed. Employed men reported occupations as laborers or service workers primarily. Employed mothers represented 14 percent of

PCC enrollees; thirty-eight percent of these women found employment in the PCC's.

Ethnic Characteristics. Four major ethnic groups were represented in the PCC's: Black, Mexican-American, American-Indian, and White rural. Distribution varied widely with geographic area, e.g. only five percent of Black families were in rural PCC's while 92 percent of Indians, 71 percent of Mexican-Americans and 69 percent of Whites were in rural PCC's. White families were enrolled in Southern urban as well as rural centers, but seldom in Northern urban centers. In addition to the major groups above, centers served a multi-racial population in Honolulu as well as Alaskan and Eskimo families. (See **Figure**, p. 33).

In the South, integration was a goal and was realized in recruitment of Black and White families while in the North, all but three PCC's recruited in line with the pattern of residential segregation. Of the 13 PCC's where the enrollment was more than 85 percent Black, 12 were in northern urban ghettos.

Psychological Characteristics of Families. PCC families represented an amazing diversity of styles, strengths, and problems. The PCC program has provided a much needed opportunity to ask questions about what poverty does to human life. The psychological impact of a heritage of poverty has only been surmised, heretofore. As a heritage, it is deeply imbedded, and like most traditions, is quite resistant to change. PCC families differed in their ability to cope with external circumstances, and these circumstances varied from place to place in the demands they made on human functioning. There is no way of knowing precisely which kinds of external pressures stretch human adaptability beyond its point of collapse, thus fostering deterioration.

Dr. Lois Murphy, after reading a number of the narrative reports of field observers wrote a statement to the research contractor of which excerpts are presented here:

> I don't see how, for instance, people who have never worked first-hand with persons from the extreme poverty group, can possibly realize the size and character - the incredible enormity of the task which has been set. For generations, if not for hundreds of years in this country, it has been assumed that everyone has the opportunity to make his life better and that, as far as external circumstances are concerned, it is easily possible for anyone to be mobile, either in terms of horizontal change from one part of the country to another to achieve greater comfort or satisfaction, or of vertical change to a "better" economic, educational or vocational situation. The fact that any combination of many, many different factors interfere with the reality of mobility, and the capacity for change is widely neglected. Most outstanding in this neglect is the situation of people such as those in a former mining

town in an isolated area. When mines become unprofitable and are shut down--as has happened over and over again in this country--and industry, with all its resources moves on without taking any responsibility for the men who have been put out of work after contributing to the productivity of the industry (and the country) and are therefore without means to provide for their families, the stage is set for sequences of serious deterioration of human life.

However, as resources continue to dwindle and there is not enough money to feed the family, mothers become undernourished, the babies with whom they are pregnant are prenatally undernourished, there is inadequate care at birth as well as before birth, the children are born vulnerable if not outright damaged, and the "stock" become less hardy than it was to start with. Without adequate food to provide energy, families take less and less adequate care of their habitation, their clothes, and themselves, including the small babies who are getting a start in life. With constant frustration and discouragement, tempers get out of control, angry reactions become commonplace, children learn to keep out of the way, and gratifying communication between adults and children including babies become minimal or nonexistent.

...This process of deterioration of the population is actively going on at present and I have seen directly some of the recent results; that is, first steps which lead to the disorganization which has been taking place for over a hundred years in some of the mining towns.

CENTER FACILITIES

It is no accident that one of the greatest frustrations in bringing PCC's to the operational stage was lack of adequate physical facilities. What should have been a short-term administrative concern consumed enormous amounts of time, energy and staff morale. Federal guidelines, the same as for Head Start, did not authorize construction expenditures. Renovation funds were also restricted. Local licensing and zoning codes added to the problems. Poverty, particularly in its extreme forms, is not typically a neighbor to adequate buildings. Even without considerations of health, building codes, and fire laws, there were few physical structures in target areas which were suitable candidates for refurbishing or renovation. When found, structures often needed considerably more than a face lift - more often they needed re-construction. The federal guidelines indicated that space for initial operation should be provided locally. In theory, a community that needs and wants a PCC should be willing to provide such minimal resources as a place for the PCC to begin. It appeared that communities and agencies which could most readily provide physical space were communities which least needed PCC's.

The buildings most likely to be converted for use as PCC's in both rural and urban areas were former private residences, (26), followed by church rooms in both rural and urban areas, (8), unused or abandoned public schools in the rural areas, (7). Commercial buildings, former stores, or in one case, a former bar building, were also utilized. Two PCC's were located in public housing facilities.

The preference for former residences may have been influenced by the federal guidelines which suggested establishing the PCC as a home-away-from-home. For the most part, the old houses were transformed to cheerful facilities which in many cases provided adequate space for a variety of activities. In other cases directors simply lacked the knowledge or experience necessary to judge the suitability of an old house and a bad choice limited the development of programs. Descriptions of two centers are presented below:

> One center still lacks adequate water, but plans are being discussed for solving this problem. Heating is a problem in both centers. They are heated by unvented gas heaters which are dangerous. The women tend to keep these facilities grossly overheated, possibly as compensation for the lack of adequate heating in their own homes. They are stuffy to the point of discomfort.

These large, two-story residences are surrounded by spacious yards which provide ideal outdoor play areas. The buildings have undergone extensive renovation since the program's inception in September, 1968, some 16 months prior to this writing. Now they are attractive facilities, very appropriately arranged, and well-equipped for their various purposes. Much of the renovation work had been done by the staff and parents and community volunteers. Much of the equipment and many furnishings have been donated or purchased at reduced prices.

While most of the eight schools used for PCC services were quite adequate, they required extensive repairs since nearly all had been condemned for use by school-age children. The eight PCC's operating in church facilities generally found quite adequate and appropriate space in the meeting rooms, as well as in unused basement rooms. A garage, a paint store, and a former tavern are now PCC's, and in these three instances the conversions worked quite well. As a bonus, they provided high visibility in the community. Public housing facilities offered PCC's proximity to families and made them an actual part of the housing complex.

Impact of Facilities on Program Vitality

The physical facilities were important elements in determining the types of programs provided and the continuity and vitality of programs once underway. Adequacy and amount of space as well as its utilization were almost as important as the traveling distance between clients and centers. Infants were not served when heating was undependable and floors too dangerous for crawling. An infant stimulation program requires, as a minimum, a safe, protected environment. As a result of inadequacies in central facilities and delays in refurbishing them, many PCC's during the initial phases of operations worked with parents in the homes. While not the most efficient use of staff (when such a program was not originally planned for), it was necessary due to the real limitations in center facilities.

HEALTH SERVICES

Physical Examinations

Research observers reported that preventive examinations and treatment services were actively carried out as part of the medical component in nearly all centers. The hard data are less complete than one might have hoped, but they are impressive nonetheless. Physicians reported physical examinations for 1,526 children, about half of those enrolled. The actual number of children examined was apparently much higher, if observers' impressions are correct. Half the children seen were in good health, with no identifiable ailments. About a fourth had a medical condition which was undiagnosed before the PCC exam. The remaining children had known medical conditions, many of which were not being properly treated. The most frequent types of illness were skin diseases, chronic respiratory infections, otitis-media, umbilical hernias, intestinal disorders, and miscellaneous infections.

Mothers reported a five percent prematurity rate, and indicated that at least half the children had received the usual immunizations. Smallpox vaccination was reported for only a fourth of the children. (Many innoculations are given over a period of time, and a number of the children were in the process of completing them.) Height and weight measures indicated that PCC children were shorter and heavier than the typical children described by growth charts. Repeated measures indicated a normal height and weight gain over nine months. While relatively few children had been screened for tuberculosis or anemia at the time of the medical reports, about three percent had positive T B tests and twenty percent or more (80 percent in one center) were anemic. It was speculated that many physicians might have delayed blood and T B tests to a later time so the children would not be frightened by these medical procedures on the first visit.

Treatment and Referrals

Acute infections and malnutrition were generally treated by examining physicians, but 1,295 referrals were made to other treatment resources, i.e. hospitals, clinics, etc. Follow-up records were difficult to obtain or to keep at centers. Where a nurse was on the staff, she usually took charge of follow-up and in addition to keeping more careful records, she provided a link between family and physician and made certain treatment was completed. Most complete information was available from centers using private physicians or employing nurses. Families felt they received better care from private doctors, although all centers seemed to have arranged for improved delivery of health care from clinics as well.

Anecdotal reports indicated that treatment encouraged by PCC's often made the difference between growing up handicapped by the effects of untreated illnesses and growing up in good health. In some cases diagnosis and treatment rescued children from early death.

Twenty PCC's provided physical examinations and medical treatment for whole families. They reported 1,968 examinations including 348 prenatal care patients. Again, observers felt the number was actually higher than the above figure was taken from statistical reports. Dental services, provided to older siblings and parents, proved to be a serious need. Most centers learned the clinic facilities could not meet the needs, and they purchased dental care. In the most comprehensive dental service offered, one center reported a total of 447 dental care appointments.

Availability of Services

Many centers had expected to use new health services provided by NSP's. Since these were often in the planning stages, temporary arrangements had to be made in the meantime. Non-NSP communities often lacked necessary services either in quantity or in quality. In some rural areas, private physicians as well as nurses were scarce and hospitals were at a considerable distance. One center arranged for a medical mobile to visit its center, a plan which worked very well.

Medical care was provided by three major sources, (1) private practitioners, (2) public sources including public health, university and group plan clinics, and (3) neighborhood health centers (OEO and HEW). Almost every center found it necessary to use more than one source of care. Several centers experimented with prepaid insurance plans, and some were comparing patient satisfaction with various types of service.

The PCC Nurse was an essential staff member although a number of centers had to make alternate arrangements to comply with the federal requirement that a nurse be employed when programs served very young children. It was the nurse who took the lead in educating staff about health and in helping para-professional staff to overcome their fears of doctors. She also examined children, helped families to understand doctors' orders, and helped medical personnel to work more effectively with families. Medical records were better kept when a nurse was on board and it was surmised that both the number of initial examinations and the completion of treatments were influenced by the presence and activities of the nurse. Nurses also provided health classes and informal consultations to family members. Health education emphasized general health, dental care, prenatal care, planned parenthood and Red Cross safety instruction. Some nurses felt that their classes were a less effective way of providing health education than their informal contacts in sewing classes, child care discussions, etc.

Psychological Obstacles to Improving Health

While health service components usually triumphed over a variety of obstacles, the attitudes of client families remained a major concern at most centers. Fear of discovering a serious illness and reluctance to accept preventive care or treatment are psychological barriers to better health which will not easily disappear even when more adequate medical services become available to everyone. For years, many PCC families have thought of doctors as a last resort, and it requires a major re-adjustment to look upon their services as related to health as well as sickness and death.

PROGRAMS FOR CHILDREN

Children Served and Frequency of Contact

Thirty-four PCC's served 2,580 preschool children in specially designed programs. (One center directed services exclusively to parents and consequently had no children's program.) Half the centers provided both home-visiting and center-based programs; 11 centers provided center programs exclusively, and six provided only home-visiting which focused on infants through work with their mothers. Most centers served toddlers, rather than infants, largely for practical reasons. Home programs tended to serve the entire range from birth through three years (the PCC target ages) as well as other children who might be present during the visits.

Following are some examples of program size and frequency of contact:

--In a western urban center, four infants and 21 toddlers were provided separate programs for 20 hours a week while their mothers attended a work study program.

--In a Rocky Mountain PCC, 24 children were provided with a home day-care program in eight homes, and 12 three- and four-year-olds attended a four-hour-per-week center program. These 36 children were also visited in their homes for 1/2 hour a week, in addition to nine children who received home visits only.

--In a southern urban project, 14 infants, 15 toddlers, and 16 runabouts were provided with a program of cognitive stimulation in separate groups for six hours a week in the center. In addition, they were visited on an individual basis in their homes for one hour a week.

--In a western urban center 19 infants were brought to the center for two hours a week by their mothers to participate in a program of infant stimulation under the direction of a Program Coordinator. The toddler program had 43 children enrolled in a center-based play group and had an average daily attendance of 30 for 15 hours a week.

--In a rural southern program, 39 children were cared for by 18 Alternate Home Mothers in the latter's homes for eight hours a week; 15 two- and three-year olds and five three- and four-year olds attended a five-hour-a-week center program; all of the children were visited in an individual home visit for three hours a week.

--In a midwestern rural PCC, 143 infants and toddlers attended five centers for five hours a week. Of the 143 children, 74 received individual home visits.

Describing the children's programs was a difficult task both because of their diversity and the early stage of their development at the time of the survey. (In the intervening months, Washington staff have arranged to document the programs, and a report will be available in the near future to describe programs in detail). Most programs for children depended for ideas, and sometimes for staff training, on the relatively few research oriented programs for infants of young children which have been operating in recent years. The extent to which the research models were adaptable to PCC's depended largely on the experience with staff-training and program administration which the researchers had to share. Most investigators, not themselves in the business of operating large-scale programs, are often unaware of the uniqueness of their resources and settings. PCC's were seldom endowed with staff who were knowledgeable about developmental theory, research, or innovative programs. Staff were seldom in a position to provide the leadership, direction or supervision which experimental programs take for granted. PCC's had broader goals and more often than experimental centers, employed untrained local personnel. They also served more children and parents, and had greater responsibility for public relations and accountability to various audiences.

The research models which were favored by PCC staff tended to be those which were designed for application in fairly structured ways, and which had clearer goals, materials, and strategies. It appeared that the attractiveness of a program model had more to do with its feasibility than with any other characteristic.

Program Examples

The richness and uniqueness of the programs are lost in any summary. The nine center and six home examples below are excerpts from reports of field associates who observed the programs first-hand. They were chosen for their diversity to offer a national bird's-eye view of PCC children's programs.

Center Programs:

--With the six-month to 18-month-old children, the emphasis is on the development of motor coordination. These children work large picture puzzles, clap hands and dance to music on a record player, and play with toys that call for varying degrees of motor coordination. As far as I could tell, very few activities are directed toward the six-month-old children. These children primarily observe the other members of the group.

--The emphasis of the entire program is on sensory stimulation, language development, and social learning. There is no question that the children enjoy themselves. The 18-month to three-year-olds use increasingly complex materials, and are introduced to counting and letters. There is a comfortably sequenced program allowing for building many skills.

--"We plan exercises for the babies to be done by the mothers to supply kinesthetic stimulation and social interactions. The mothers are also taught to reinforce the behavior with a smile, talk or pat. The exercises have been worked out for each age group of the babies. These exercises are designed to help the baby improve his own body mastery. I demonstrate each exercise on a baby and ask for a return demonstration by the mother under my supervision each time. I offer an explanation as to why we do each exercise. We do some stimulation for development, simple games designed to help develop the visual, audio, sensory, perception, emotional and social development. Each stimulation is explained to the mother and the expected responses that we may encounter are explained to the mother. I find that making an explanation step by step encourages the mother and helps her to participate in each exercise. The mother is continually encouraged to reward the baby with smiles, pats and even picking up the child and hugging."

--An official requirement is that each mother or mother substitute must participate in the first hour of the "training program," where they are to learn the different ways of "working with the children." Typically these most active mothers participate with the teachers in encouraging the children to play with, or attend to, various pieces of equipment or sources of sensory stimulation. Each age group is scheduled for five or six children on any one day, but full attendance is rare. Each teacher reported that about one-third of her parents (mothers) could be considered very actively involved. After the first hour, the mothers are invited to participate in various programs regarding nutrition, health, sewing, and other domestic skills.

--Both teachers are young and enthusiastic about child care and development. They are remarkably untrained in the age group for which they are responsible. The senior teacher underestimated the age of her toddlers to be more than a year on three different occasions; had she had any awareness of developmental levels in the years one through three she would not have erred to this degree. On the other hand, this teacher is devoted to her work. She does more cognitive stimulation and language training than I saw at other centers. Even her work falls short of what could be done if she had sophisticated consultation and training.

--One Child Care Worker has primary responsibility for the infants served at the Center. In this capacity she feeds them while holding and talking to them, changes them, and generally meets their physical needs. They are stimulated while awake but not necessarily in such a manner to progressively promote cognitive development. Conversations with these workers reveal they were acting intuitively and not in relation to training received at PCC.

--It appears that the nursery program is more or less a traditional day-care operation, with demonstrations by the research and evaluation coordinator and the curriculum coordinator being used to move teachers and parents gradually to adopt the stimulation techniques developed by Florida's Gordon Project.

--There is no doubt that this is a good program for the children. It is a rich environment--emotionally, cognitively, physically. It is a child-centered environment-inside, outside, everywhere. It is a child-oriented staff--but then, that is the Eskimo way! There is little doubt that it is a good program.

--She has a real capacity for developing rapport with children but lacks the simple skills one picks up under effective supervised training; e.g., she moves in on children too rapidly and tends to tower over them. In general, the staff seemed oriented to cognitively aimless activity with children. Contacts were of the type one finds made by nonspecialists who more or less enjoy children and engage with them in social chatter, mild teasing, and some affection.

Home Programs:

--The home-visiting staff, now that they have a beginning caseload, appear to be fairly active. As mentioned, they have started their round of home visitations. Thus far, they have no specific program to follow in making these visits, other than to look for generalized ways of helping and to inform the families about PCC schedules and programs. There is indication that a rather strong paternalistic orientation exists in the home worker staff despite their so-called status as resident types.

--From all accounts, the Infant Stimulation provided by the parent educators is the most successful phase of the PCC program. Ira Gordon's Florida model is the basis of this program. I think the acceptance of the parents and the enthusiasm of the PCC staff can be best documented by the fact that the program is presently expanding the basic Florida sequence of stimulation exercises by a series of their own making. There is a local attempt to pre-

pare materials for the next age group beyond that provided for in the Florida sequence of activities. The Child Development Supervisor is supervising this project, but the exercises are being developed jointly with the parent educators.

--The Family Education Aides visit the homes for three one-hour sessions each week for the purpose of "stimulating" children in the development of cognitive and psychomotor abilities. The skills and rationale of stimulation are also taught to the mothers so that they can increase their own effectiveness in adding to the development of their children. The mothers must be present during the visits of the aides, each of whom is responsible for work with about five families. As a part of their task the aides also talk with the mothers about their children--what they eat, how they play, toilet training, and their sleep habits, etc. The rapport between mother and aide is also enhanced by the opportunity to learn about problems the family is facing and to make the necessary suggestions to the mother as to where she might get help. The aides also take the initiative themselves on many occasions and get the help for a needy family. During the approximately 45 minutes the teacher and I observed there was considerable activity by the teachers in talking to the children, reading and looking at books, playing with a ball, and building block towers. The infants were held and talked to, they played with toy animals, and looked into a mirror. The atmosphere was both natural and friendly. The aides seemed to have established good rapport and the mother discussed infant feeding, sleeping, and toilet training quite freely, as well as relating anecdotes of her sons' behavior of recent days. There was little verbalizing from the two boys, a pattern that, according to the training coordinator, is rather common among children of the center. She stressed that improvement in this ability is one of the major efforts.

Local Variations:

--In a southern state where group care of infants is illegal, a program was developed that not only served PCC families, but also provided useful productive jobs for senior citizens. "Senior Friends" visit PCC children in their own homes and provide care for the children while the mothers attend center functions. The "Friends," who are over 60, received a training program that prepared them for their jobs with the children. The stability and lack of turnover of the elderly is one indication of the enthusiasm with which this program has been received.

--In a rural southern community, Alternate Home Mothers provide day care for the children of PCC families. The children are exposed to a variety of experiences that are found in most middle-class homes. The concept of the Alternate Home Program implies that by providing the child with a rich environment and giving some relief to mothers, the child will benefit and be provided some of the experiences necessary for a later, healthy development.

Implicit Program Philosophies

While the segments of programs listed above are too brief to convey much about the philosophies they reflect, it is important to consider the theoretical or philosophical underpinnings of the children's programs. In many cases there was no conscious model which guided either the director or the staff who worked with children, although often there was an implicit philosophy which pervaded the program. In a very general way one might classify programs into two general groups, those emphasizing a cognitive stimulation approach (eight PCC's) and those emphasizing a general developmental approach (22 PCC's) with the remainder combining both approaches.

The cognitive stimulation model draws its impetus from recent research findings which indicate that young children are capable of greater learning in their early years than we previously considered possible. Experimental programs have demonstrated that young children enjoy learning when they are given age-appropriate materials and guidance. Moreover, it is becoming more apparent that the "hidden curriculum of the middle class home" offers more privileged children a rich education in their early years. Mothers and children of all social classes have enjoyed learning from Sesame Street. Those who can afford educational toys and books are consuming new materials as soon as they reach the market. Cognitive stimulation programs reflect this current interest in early education. Characteristically cognitive programs have limited goals, a focused plan for activities, and carefully selected materials. Child care workers in these programs tend to be warm and concerned adults who meet many developmental needs in their interactions with the children, although they do not emphasize those aspects of their programs.

Programs with a general development orientation are concerned with fostering the growth of a whole child by meeting individual growth needs and by providing a growth facilitating environment. These programs draw heavily from theories and experiences which suggest that children will develop optimally in a supportive environment. At this stage in our knowledge of human development, no one is able to spell-out clearly what constitutes the supportive environment. Some programs which express allegiance to this model do it an injustice since they provide merely

passive, non-injurious custodial care. Others, usually those which employ experienced child-development staff or consultants, provide sensitive, individual attention to children's needs, interests and styles, and tailor the space, play materials and interpersonal environment to encourage optimal development. The comprehensiveness of the general development approach offers many advantages but it also requires a refined understanding of children, experience in observing and guiding them, and ability to translate understanding into relevant programming. A good general development program usually includes considerable cognitive stimulation, and in some ways this model can be looked upon as an umbrella or mega-model which under ideal conditions integrates a wide range of theory and practice to provide a "good life for infants and toddlers."

Staffing

There were considerable variations in the professional-paraprofessional staff ratios in the programs for children. Virtually all centers had some paraprofessionals working with children. Selection for warmth, concern, and interest in children was found to be more important than education or other qualifications. Training and supervision, both in kind and intensity were crucial factors in effective performance of caretaking or teaching roles. The most effective training was geared to program development as well as to individual staff needs. Such training provided relatively focused goals, content and rationales for the staff. Individual supervision was an essential component of the training to help staff deal with personal concerns which interacted with their caretaking roles.

It was the overall impression of research observers that staff training at most centers was weak in relation to children's programs. Despite the heavy emphasis placed on training by the Headquarters staff, often according to observer reports, there was no professional staff member who could offer the requisite training or supervision, nor were such personnel readily available for employment or consultation. Everyone learned from the children! Such things as choice of furniture, toys, group activities, etc. indicated how little is commonly known about the behavior and needs of children under three. The FCC's were in many instances laboratories for trial and error learning about young children's needs and potentials. (Informal reports indicate that many centers have since developed innovative, exciting, and effective infant education models.)

There appeared to be clear training advantages to the cognitive stimulation approach, in centers where it was used. The Gordon model seemed to be an excellent first step for training staff in any child program since it provided a limited focus, a strategy, and a set of materials. Any program which chooses the broader developmental approach

can expand staff training gradually by apprenticeship, supervision, and other types of in-service training. Few programs have intentionally combined both cognitive stimulation and general development approaches, although some appeared to be moving in that direction. In the hands of inexperienced and/or paraprofessional staff, children's programs where goals were limited, focused, and easily understood generated the greatest vitality, enthusiasm, and potential for expansion.

Despite the problems encountered in staff development, mothers who worked as staff seemed to gain much from the "apprenticeship" experience. Changes were observable in their conversations and their behavior with children at the centers as well as with their own children. They made rapid gains in their understanding of young children, and came to enjoy interacting with them more than they did before PCC's came into existence.

Problems in Delivering Programs for Children

The physical facilities available for most PCC operations proved inadequate for many of the proposed programs. Size, heating, and safety factors were among the most common obstacles. Distance and transportation were added problems in rural settings. Some states prohibited group activities or group gatherings for infants which made center programs impossible. On the whole this first year of operation was a difficult one for most PCC children's programs. Some of the problems will undoubtedly disappear with experience and better training while others will probably persist as testimony to the newness of the PCC concept. The forthcoming report which will document some of the better programs for children should fill the information gap for centers which need help in developing stronger children's programs.

PROGRAMS FOR PARENTS AND FAMILY MEMBERS

Centers have developed a wide variety of programs for mothers. Fathers and other family members have less often participated in programs, and it also appears that few programs were deliberately designed for them. A few centers focused on social services to parents (primarily mothers) rather than on programs for children in the belief that parents not only have the primary responsibility for their children, but also that their earning power, knowledge of child development, and feelings of self worth have a pervasive influence on their child-rearing practices. Other centers took a more educational approach to parents' programs, and offered a variety of courses in child development, sewing, family management, etc., as well as offering child programs. Most centers offered a full range of programs in which parents participated as:

-- members of Policy Advisory Committees.

-- members of PCC Staff or volunteers.

-- participants in staff training classes.

-- students in classes on child development, sewing, budgeting, charm, etc.

-- participants in home-teaching programs.

-- recipients of medical, counseling, psythotherapy and social services.

Parent Participation. During the first year of operations, centers learned ways of recruiting and gaining the attendance of parents in PCC activities, ways of holding their interest after attendance had been secured, and techniques to encourage staff to support parent activities. The following were among the more successful ways of getting parents to attend programs:

--using a personal invitation instead of a posted notice or mailed one.

--providing baby-sitting service.

--providing refreshments or a meal.

--encouraging parents to participate in selection of programs.

--providing transportation.

--providing for men's interests and providing male workers.

Social Services

The target group of staff assigned to any program component was social workers, most of them paraprofessionals working with professional direction. They provided four types of service: material, social, psychological, and community. Meeting material needs consumed nearly one third of staff time. This category included transportation to centers and other service agencies, emergency food, assistance in finding housing or in applying for jobs or welfare funds. Paraprofessionals performed well in this capacity, particularly in those centers serving families with overwhelming material problems. As one worker commented; "Cognitive stimulation won't feed a hungry baby."

The social isolation of many families, especially mothers, stimulated a number of programs which combined education and use of community resources with social interaction, meetings away from home, movies, crafts, coffee hours, pot-luck suppers, etc. Field observers felt the social programs were highly beneficial in bringing isolated people together under pleasant conditions, thus laying the groundwork for other programs. Home-visits might be included among social services since many women were benefited just by knowing someone would come to visit without making demands. Psychological services, in the form of individual or group counseling and psychotherapy were offered directly in five centers and through referral sources in many others. One center developed a walk-in clinic operated by paraprofessionals, under the direction of Ph.D. candidates in psychology. Community resources were made known to clients and their services made more relevant to client needs. Directors used a variety of techniques for helping (pressuring) existing service agencies to change in ways in which would benefit a wider clientele.

There have been questions raised about the heavy social service emphasis in some centers which may define their clients as "sick" and the PCC program as a "cure." Client needs varied considerably from center to center so it was a matter of opinion just how much and what kind of social service was needed. What appeared to be emerging in some centers were new models of outreach and supportive services which helped isolated families to become engaged with resources and programs which could help them towards a better life.

Parent Education Programs

Educational programs included, (1) didactic lectures, discussions and seminars, and (2) participant observation via employment, home teaching, and involvement in center programs for children.

Classes in child development reached a third of all enrolled mothers. Fifty-one fathers and twelve other family members also attended these courses. Classes were usually small and consisted of lectures, films and discussions. Where it was possible, specialists and university faculty participated and in some cases college credits were provided for these courses. The major benefits were: (1) enlightenment about the effectiveness of rewards as opposed to punishments in shaping children's behavior, and (2) the power of demonstrations which gave mothers clear examples of new ideas at work, and encouraged them to see if they would work in their families. It was noted that (1) demonstrations and participatory programs were more effective than lectures or other didactic approaches, and (2) that "experts" must make haste slowly in asking mothers to re-consider their child-rearing ideas or practices. Children are "all they have" for many mothers, and their need to protect these relationships from intrusion is understandable and deserving of respect.

Family Management classes included a wide range of topics, and enrolled 1,783 participants, almost all of them mothers. Most centers learned that it was more important to tailor classes to meet the needs and interests of participating parents, than to plan ideal programs according to staff beliefs. Sewing and cooking classes were extremely popular. These two classes not only taught skills and provided social contact while their babies were well cared for, but also allowed for producing small gifts to bring home for husbands or family. Family management classes often included the teaching of elemental skills such as reading, measuring or counting. Sensitive staff often used the informality of the classes to find ways of helping families who needed their services. In one center a nurse came to sewing and cooking classes to talk about the importance of iron-rich foods in combatting anemia.

Job Skills training was mostly on-the-job during the first year. Ninety-seven mothers, 16 fathers, and 33 other family members were employed by the centers. The men had traditional jobs such as janitor, cook or driver while the women often filled some of the newer jobs which have developed from HeadStart, e.g., social work aide, teacher aide, community outreach worker, etc. Six PCC's trained mothers to provide day care in their homes, and others had expected to launch similar programs but local licensing code restrictions interfered. The only really new job which has emerged from the first PCC year is "Infant Educator". The role was developed by Dr. Ira Gordon in Florida, and involves training women to bring toys and other materials into homes and to demonstrate their use with infants and young children. While there was little job training underway which did not relate to PCC operations, most observers felt that the model of training-plus-employment was most successful. Of all benefits noted in the PCC program, changes in mothers who worked at centers was the most exciting.

Child-care training for non-center jobs was developing at six centers for 81 mothers. One center trained mothers in play techniques with children.

Volunteer roles, other than traditional ones, emerged in the form of Senior Friends and Alternate Home Mothers. Senior Friends were older citizens who visited children and cared for them during parent meetings, thus providing special attention for children and satisfaction for themselves. Alternate Home Mothers cared for PCC children on occasion and offered them a variety of supplementary experienced common to middle class homes.

Basic Education was provided about a third of the centers and enrolled 199 mothers and 74 fathers. Continuing education classes drew more fathers than any other program. Classes were often provided through adult divisions of public schools or junior colleges.

Job counseling was provided by six centers to 60 individuals. Most centers referred individuals to other agencies for this service.

Additional Educational Classes. A wide variety of classes developed from interest, among them auto repair, home repair, driver training, typing, woodworking, etc.

Home Visiting Programs

Home-visiting as well as parent participation in children's center programs provided non-didactic education for parents. In both instances the staff member used herself as a teacher for the child and a model or example for the mother. Staff seldom challenged the child-rearing practices of mothers. Instead they demonstrated workable alternatives for dealing with young children. For home programs, it was important that the staff visitor be accepted in the home on a continuing basis which meant that she must become a welcome visitor for mother as well as child. Mothers often liked the idea that a center staff member cared enough to visit regularly. The visits provided a way for mothers to break through their feelings of isolation and loneliness plus an experience with an agency representative who did not make threats or arouse anxiety about their worth.

Experiments in Payment to Mothers

While many mothers received wages as staff members, three centers established incentive payments to encourage mothers to participate in child development or home management classes. One center paid $5.00 per half day, with a $1,200 annual maximum. Mothers in this program sometimes felt they were low salaried staff. Another center offered a

$600 family allowance for specified needs. A third center pays up to $400 a year at a rate of $8.00 a week for four hours attendance, a plan which generated fewer problems than the other incentive plans. Small payments were associated with higher involvement and change than larger payments. One field observer felt that attendance was not notably influenced by payments. More time is needed before the incentive plans can be evaluated.

PERSONNEL PRACTICES

Selection

In December 1969, 943 staff were reported working in the centers. PCC's were paying the salaries of 553 full-time and 145 part-time staff. More than a third as many additional staff were contributing services to the centers as volunteers or as employees of other agencies. Figures probably reflect only those volunteers working on a regular basis in the centers, and do not take into consideration other volunteer resources or services contributed by the community.

While it was intended that Policy Advisory Committees would hire Directors, in practice most directors were hired by Community Action Agencies before the PAC's were functional. Directors hired the other professional and paraprofessional staff usually with the assistance of the PAC's whose development was one of the director's early tasks. Women directors outnumbered men by more than two-to-one. More than half of the directors were White, followed closely by Black, with one director each from Eskimo, Puerto Rican and Mexican-American backgrounds. Most directors had college or graduate degrees in education, social sciences or social work, and had a variety of work experiences. Their annual salaries ranged from $7,000 to $12,000, not particularly high considering the professional and managerial demands of the job. By the end of 1969, more than one third of the original directors had been replaced.

The director's education and experiences were major influences on the programs which developed. A center often implicitly "bought" a program when they hired a director which ran counter to the plan for evolving programs under the guidance of the PAC's. Since directors tended to hire additional professional staff in keeping with their implicit (or explicit) program plans, the very process of staff selection often reinforced his biases. Social workers and educators were the most frequently hired professional staff. Nurses were hired by many centers, but seemed under-represented in view of the great need for their services and expertise which was apparent in centers where they were active.

Paraprofessionals were recruited from the target areas as required by the guidelines. In communities where pressures did not interfere, a variety of selection procedures was used. Generally speaking, selection was most satisfactory when personal qualities such as warmth, consistency, interest in learning, and desire to make the program succeed were emphasized over educational qualifications.

Clerical staff were hired by some directors, while others filled these positions with untrained people, which led to the rediscovery of

how indispensable an experienced office manager or secretary can be in organizing and maintaining records!

Considering the staff as a whole, only 14 percent were men, and these were usually in administrative or maintenance roles. One staff member in every four was under 24 years of age; six out of ten were under 35. One in five had completed college, half had finished high school, and the remainder had not gone beyond tenth grade. Six out of ten lived within the PCC target area, and as expected they were usually the paraprofessionals. Two centers reported that only one of ten staff positions was filled by someone living outside the target area. Ethnicity of staff paralleled that of clients, the largest single group being Black and living in major cities. (See Figure, p. 33) Most White Staff and clients were at Appalachian centers. While in the South integration was encouraged, in the north, Black staff were sought. About one-third of all staff had worked in other poverty programs, particularly Head Start, before joining the PCC's.

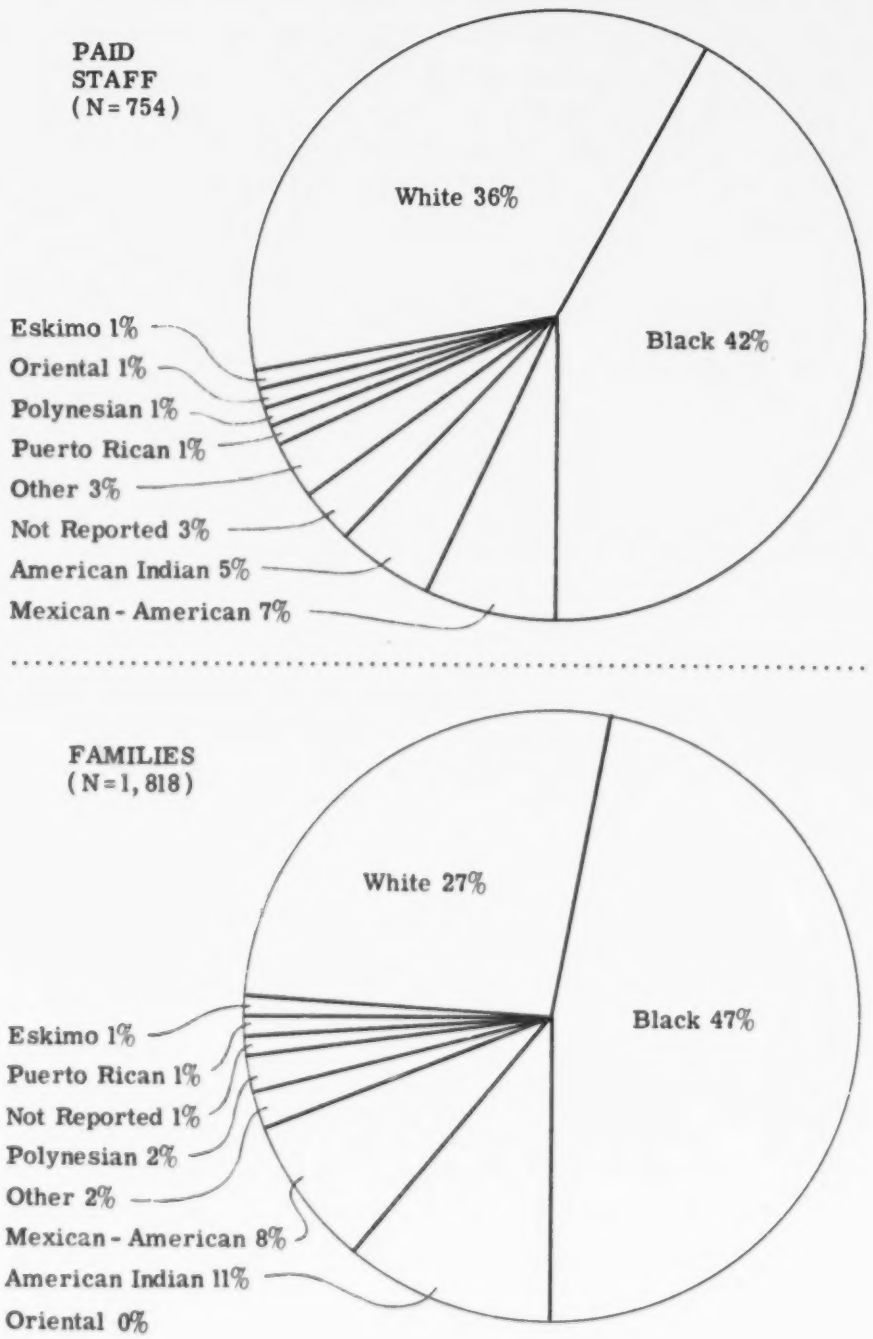
Training

Training was to be provided for all levels of staff, but there was a particular emphasis on job-training and development of "new careers" for paraprofessionals from the target areas. The Washington Headquarters placed heavy emphasis on training, and provided considerable input in the form of consultation, workshops, mini-conferences and materials with particular reference to the development of young children. Most centers operated pre-service as well as in-service training programs. Because of high staff turnover, many centers lost much of their initial pre-service investment, and this factor interfered with on-going training. Four PCC's arranged for staff training outside the centers under the direction of child development experts.

There was a discrepancy between what field associates observed about training and its results in comparison with national office and local investments in training. On the one hand there were no "baseline" data for the knowledge or skill of paraprofessional (and to a lesser extent the professional) staff. Thus, what looked like inadequate training results in some centers may in fact have represented considerable progress from an earlier stage. On the other hand, it is likely that the emphasis on didactic teaching in many centers resulted in limited carry-over into practice. The fact that so much was invested in training, but that so much still needed to be done was among the important findings of the national survey.

During the first year of operation, training resources were devoted largely to paraprofessional staff. Few centers had the resources to devote to professional development, (although a need exists) or to creation of new careers programs for the training of non-staff from target areas.

ETHNIC COMPOSITION OF PCC STAFF AND FAMILIES



Staff attendance, performance, and turnover were overwhelming problems at some centers, and on the whole were among the more serious difficulties encountered in the first year. Centers which had outreach and home visiting programs suffered most, and the problems increased as the program focus decreased. From a management and staff development point-of-view, training, supervision, role definitions, program goals and implementation all need to be planned carefully when inexperienced paraprofessional staff are expected to function independently on field assignments. While turnover has been alarming at some centers, where it has seriously interfered with program development, it represents achievement of one PCC goal, i.e. to provide employment skills to target area residents. The majority of paraprofessionals who have left programs have done so for alternate employment, whereas most were formerly unemployed.

Human relations conflicts among staff have been the rule rather than the exception. By and large they were typical conflicts and they were used to help programs grow-up in many instances. While conflicts drained administrative time, and certainly lowered operating efficiency, there was no evidence that children or client families were hurt by them. On the whole one gleans a picture of emotional intensity, running hot and cold; a picture relatively devoid of lukeward or neutral interpersonal behavior.

IMPACT OF PCC PROGRAMS ON CHILDREN, FAMILIES, AND COMMUNITIES

Accurate assessment of any social intervention program requires that we look in many places. The probable impacts described below represent judgments about first year operations, and as such must be considered both tentative and incomplete. The Survey was intended as a study of inputs not outputs. Nevertheless there are suggestive findings.

Impacts on Children

Health services to children represented a major contribution to facilitating their healthy development. Observers noted that at the centers which were well underway, the children looked healthier, had better color, were more active, less irritable, more cheerful than they were earlier in the program.

Increased understanding of child development and changes in parent-child relationships were observed particularly among mothers employed as PCC staff. Many other mothers learned more about raising their children and enjoyed them more because of what they learned. It appeared that many of the benefits to children were indirectly the result of the mothers' growth as individuals.

Children in six centers were given the Bayley Scales of Infant Development twice over a ten month period. This standardized test of infant development provided both descriptive information about the children who enrolled at PCC's, and hints about the effects of children's programs on their development. At the time of the first testing the children, averaging about one year of age, tested close to national norms on mental development tasks. After 10 months in center programs, the improvements in motor scale scores brought the group (79 children available for both pre-test and retest) to the national average (a gain of 7.3 scale points from a mean pretest score of 91.1 to a mean retest score of 98.4). The average mental scale score gain was 10.3 points, bringing scores for a number of children within the average range (from a mean pretest score of 77.4 to a mean retest score of 87.7). These gains are quite respectable when compared with those reported by investigators who are studying effects of carefully planned infant stimulation programs.

The Bayley scores did not relate to ethnicity, geographic location or rate of infant mortality in the local region. Sex differences were unstable and no clearcut pattern could be established. Two findings needing further careful study were, (1) Bayley scores declined as children

got older and (2) during the second year of life, some children "drop" in Bayley scores, recovering later. The data are insufficient to say more except to point-up a phenomenon observed by a number of investigators interested in the effects of poverty on early development.

While there was no clear indication that one children's program fostered development more than another, the greatest gains seemed to be associated with well organized programs where goals and methods were clear to staff and observable by outsiders.

Impacts on Parents and Other Family Members

Improved health was reported consistently for mothers and to a lesser extent for other family members. Women had visibly greater vitality and feelings of well-being. Some received prenatal care or medical treatment, others were examined and assured of good health. Many learned about health care, nutrition, planned parenthood and first aid procedures. Dental work relieved many of pain and helped them to become more satisfied with their appearance. Other family members had opportunities for examinations, treatment and education. While preventive health education remained a problem in most communities, medical services were among the most effective and well-received components of center programs.

Parents who worked as staff changed more than any other client group. The gains were not solely, or even primarily economic. Despite the many problems encountered in training and supervising paraprofessional community residents, their growth as individuals and the changes in their appearance, self-concepts, and child-rearing behavior were strikingly visible to observers. Identification with the centers as active, contributing workers, who are helping to change their lives and those of others is the favored explanation for the changes.

Favorable effects on family life were reported by most centers. While many of the observed changes were in terms of improvements in housekeeping and personal appearance, improved family relationships and increased involvement in social and community life were also noted. Observers reported that better family relationships were often a function of the mothers' increased independence and self-confidence. There was speculation that for some mothers increased independence occasioned marital strife, separation, and divorce. Emphasis on fathers was minimal in most programs which may have unwittingly implied that only mothers were important in the view of both centers and federal agencies.

Training and Employment. A 13 percent increase in employment was reported for mothers as compared to one percent for fathers. Most of the women were trained and employed within the centers, but some were moving out to new jobs. One of the headaches of center directors was

turnover in paraprofessional staff who had found better jobs which made use of their training. The goal of training target area residents for economic independence was often accomplished at the expense of staff continuity and its realization was a mixed blessing. (Centers were just beginning non-staff training programs towards the end of the survey.)

Enhancement of Pride, Hope, and Power. A pervasive but difficult to define effect of the PCC's was the feeling of pride and power experienced by many parents who benefited from planning as well as participating in programs. For many, there was an increased sense of hope that life was worth the pain, and that their efforts might now bring about a better life for themselves and their children. It was hard to tell how much the client - participation model was responsible for the changes observed, by contrast with education, employment or better health. In those centers where parents were participating actively in making policies and plans, there appeared to be a serious and energetic commitment to improving the quality of life in the community.

Impact on Communities

Collaboration Among Community Agencies. In many communities, particularly in rural areas, PCC's gained high visibility and were effective in bringing together a variety of agencies which serve children and families. They often stimulated and supported change in methods for delivering services. The excellent effects reported by some PCC's in this regard augur well for their future as multi-purpose coordination and demonstration centers which can serve to mobilize and expand existing resources.

Intercultural, Interclass and Interdisciplinary Sharing. Greater understanding as well as sometimes bitter conflict occurred among staff members who came from diverse experiential backgrounds and among service agencies in the communities. The melting pot atmosphere of the PCC's provided new opportunities for knowing and understanding people of other classes, races, and disciplines. It also brought into the centers the conflicts typically encountered between various groups. Conflict was a source of strength when dealt with as a reality and handled skillfully. Centers which accomplished worthwhile goals almost always experienced conflict. These conflicts appeared to be the inevitable by-product of the process of social change rather than an indication of poor management.

Direction versus Magic in Child-rearing. As one reads between the lines one sees emerging in the lives of clients, staff, and the various communities concerned with PCC programs, a growing belief in the potential of young children, together with an awareness of how vividly children reflect the quality of life around them. Recognition that choices can be made in the rearing of American children, and that their

development need not be a matter of magic or chance is the sort of impact which affects society as a whole, as well as the children and parents who are the primary clientele of the Parent-Child Centers.

COST ANALYSIS

The data collected during the initial stages of operation did not lend itself to a cost analysis study. As a result, only crude estimates can be made concerning the costs of the program.

For the first developmental year, it was estimated that the 36 PCC's would cost six million dollars in federal funds and an additional 20 percent in non-federal funds. Given these figures, the allocation of federal monies per center was $175,000 with an anticipated $43,750 contributed as the non-federal share bringing the total estimated amount to $218,750 for each center. If 100 focal children in families of approximately six members each were served in each center, estimated costs would be $2187 per child or $364 per individual (combining both federal and non-federal share). Federal costs would be about $1750 per child or $291 per individual.

Actual federal expenditures for 29 centers, which had been in operation for one year on July 1, 1969, averaged $126,109 per center, approximately $49,000 less than estimated. (Start-up problems and low enrollments probably account for this difference.) The following averages are based on families being served as of July 1, 1969. (They exclude the 408 children and families who had been served during that year but who had terminated.) There were 1,337 families, 1,941 focal children and 7,800 individuals actively enrolled in PCC programs on July 1, 1969. Annual federal expenditures, on this basis, averaged $2,737 per family, $1,885 per child, and $469 per individual. The **federal costs per child** were about seven percent above the original estimates, but in view of the developmental nature of first year costs, the actual and estimated costs were reasonably comparable.[1]

In analyzing the first year costs of a brand new program, it is essential to distinguish between development expenditures and operating expenditures. The first jet passenger airplane cost 300 million dollars to build, whereas we can now build one for 15 million! While we cannot expect the efficiency of human services programs to follow production criteria suitable for manufacturing airplanes, it is reasonable to expect PCC operating costs to decrease as programs are refined and enrollments increased.

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1. These figures are taken from administrative records and from the August 1969 Kirschner Associates Progress Report, #16. Not included in any center costs was the $400,000 to $500,000 budgeted for federal administration of the programs.

LESSONS FROM THE FIRST YEAR

The experiences of the first developmental year of PCC operations taught many lessons, some of which could have been anticipated, others not. Better management might have made more effective use of these lessons in some instances but the reader is reminded that PCC's gave us opportunities to test out many ideas previously untried. The major lessons are summarized here:

1. We know very little about translating complex ideas into practice, and less about how to manage programs established to attack the interlocking problems which hinder children's development. Time will be needed to give the PCC idea a real test.

2. New programs which depart from traditional practices need to direct their energies to developing workable models. Instead, enormous amounts of time and energy have been consumed by organizational, administrative and political problems. Everyone seems to know what's best for people, despite the fact that people are more complex than spaceships about which no one claims to be an expert. PCC's need as much official protection as space programs. Problems of an organizational variety have plagued the PCC program from its conception to its delivery of services in target areas. The dollar costs of these conflicts have certainly not been in the interests of either social progress or economy.

3. Policy Advisory Committees represent a new concept which was difficult to translate into practice. Target area residents need assistance in learning how to function in working relationships with professional people whom they may hold in awe (or in contempt). Professional people also need help in learning to share the stage with clients and to respect and accept their contributions. While there are some professional values which should not be compromised there are many traditions and customs whose usefulness can be questioned. Conflicts between professionals and clients are inherent in shared planning and should not discourage continuing efforts at "creative accomodation."

4. A hierarchy of program development goals is a missing essential in many PCC's. The PCC idea includes many components which will be no more effective than the existing fragmented resources if they develop haphazardly. Centers should probably build first those components they are best equipped to handle, be sure the components are working together, and only they move in some systematic fashion to develop and integrate additional components.

5. There is a serious scarcity of professionally talented individuals equipped to direct PCC's. In addition, many professional people are reluctant to commit their time to programs plagued by federal funding uncertanties and organizational conflicts. Because no professional discipline and few individuals are prepared for the complex leadership roles demanded by PCC's, consultation services from a variety of sources are very necessary. In particular, management consultants might bring to bear their experiences with industrial change, and assist in writing job descriptions from the emerging role examples provided by PCC directors. They can also suggest appropriate training for directors and offer ongoing consultation to directors.

Other professional personnel are also scarce, and those committed to traditional ways of operating sometimes lack the flexibility necessary to try new things. In addition to selectivity in hiring, some type of "retreading", possibly centralized for several centers, would be helpful. Sensitivity techniques have been used to advantage, and extensive immersion (apprenticeship) in model programs is also effective.

6. Training of paraprofessionals is an area in which there was a heavy investment, but uneven, and sometimes disappointing results. A great deal of the training was conducted in lectures or discussions and through written materials. Apprenticeship and individual work supervision were used extensively in centers where the results of training were most in evidence. Such individualized training is costly in the short-run, but may well have effects which are economical in the long run. Much remains to be learned about selection of trainees. The potential trainees are a heterogeneous group, and not all are suited to all jobs, nor to all types of training experiences. Those who are difficult to motivate and teach cannot be ignored. On the other hand, a select group of core paraprofessional staff must be maintained by centers if programs are to develop any stability, and if trainees are to have appropriate role models. This group must be paid competitive salaries to guarantee continuity in center staff, and a balance between training and service goals.

To some extent training of non-staff for economic independence should be kept separate from staff training, or at least the difference should be clarified so that graduating to staff positions is not viewed as the only measure of success. PCC's are going to be dealing more and more with problems of work-habits, attitudes, and personality characteristics, as trainees question criteria for success in training. Some of the wisdom of recent national and industrial training programs should be available on a consulting basis so PCC training programs can benefit from their knowledge and avoid replication of mistakes.

Within training programs, professional people need to re-tool in order to meet the training needs of paraprofessionals. Apparently, many centers were dissatisfied with the academics and specialists avail-

able to them. Workshops would seem to be in order to prepare professionals for effective teaching roles. In an age when folk wisdom has been glorified we cannot risk failure in educational programs for paraprofessionals. It is a subtle form of paternalism to assure paraprofessionals that in order to be effective workers, common sense is all they need. To be sure, knowledge without common sense is useless, but the reverse is a betrayal of reason.

7. Facilities. Funds were not provided for new construction, purchasing of buildings, or major reconstruction of existing facilities. Since the facilities available in many locations were too inadequate to permit development of proposed programs, it is important to reconsider the use of federal funds for creating appropriate physical accomodations for PCC's. The cost in time, morale, and loss of service occasioned by problems with facilities was not in the interests of economy or efficiency. In addition, there is a need for technical assistance to center directors to assist them in (1) choosing appropriate facilities, (2) negotiating for their purchase, reconstruction, or renovation, and (3) planning flexible and efficient use of interior space for center programs. Retired contractors, construction foremen, and architects would be a source of help if records of their location and availability were coordinated by the Washington staff. (SCORE is a business example of this model.)

8. Health Services. In general, medical programs appeared to achieve a great many of their goals in the first year, although record keeping was inadequate in many instances and it was difficult to compare the quality of services at various centers. Nurses were of great value but were not on the staff at all centers. Tests for anemia were done infrequently, but where they were done many children were found to be anemic. Tests for lead poisoning were not reported, but in view of the findings of many medical workers in poverty areas, there are likely to be PCC children with dangerously high lead levels in their blood, resulting from ingestion of chipped paint and plaster in their homes.

9. Programs for Families. That fathers were so few in PCC programs was not surprising, although few observers felt they were recruited either appropriately or with sufficient energy. Many centers focused on mothers in a way that made fathers appear unimportant. Few centers had male staff who could work with fathers. The successes of centers which hired local men as staff indicates that fathers can be involved. PCC's have not sufficiently emphasized the importance of men in the family or in the community, although this was one of the goals of the program. The excuse that men are disinterested or unmotivated only states the problem; it is not a final answer.

Older siblings of PCC children were minimally involved at most centers. Their inclusion will be important if centers are to have maximum effect on child-rearing patterns in target areas. Older children can

learn about child development and improve their current practices with younger siblings and prepare for rearing their own children in the future.

On the whole, parent determination of programs has fostered a high degree of participation. While professional staff tended to emphasize child-rearing, parents wanted programs which at first glance appear unrelated to children. In this regard it is important to recognize that we must meet the client where he or she is and not expect professional goals and parental goals to be immediately congruent.

Basic human needs were so desperate at some centers that meeting health, sanitation, food and housing needs took priority over educational or human development goals. It is important to survey the real and felt needs of families in target areas before judging PCC programs. Some families have such basic physical needs that these must be met before more elaborate programs can develop. Sick, cold, or hungry people are not "well-motivated" for "progressive" programs.

10. Programs for Children. Children's programs have been slow to develop in some centers. It is important to guarantee complete medical care for all target children which should include some type of developmental assessment of each child, with programs then designed to meet their needs. There is no "best" program for a given center which can be determined in the absence of careful assessment of the children enrolled there. Anthropologists, nurses, pediatricians, psychologists, etc. need to contribute their skills to the assessment task. The PCC children's programs need to supplement and complement family child-care practices since there is a potential danger in programs which directly or indirectly clash with the influences of other socializing influences in the children's lives. PCC's have not effectively integrated programs for children and those for siblings and adults. The challenge of coordination and integration is a major one, and although its realization will take some time, it should be kept in focus.

Some attention should be given to the design of home visitor programs to insure that they offer optimal investment in children and families for the time spent. While visits do meet a social need and break the pattern of isolation which debilitates so many mothers, there seems a danger (at some centers) in ignoring the fact that the social value of a visit is not lost when materials, information and infant stimulation are provided in a non-intrusive manner.

Some pressing needs of children's programs are already being met. Documented descriptions of exemplary programs, lists of toys, materials, and activities appropriate for various ages, including some invented by PCC parents and staff, will be available by late 1970.

11. Interdisciplinary Leadership. PCC's require the ideas and experiences of all kinds of people. That most PCC's were dominated by either educators or social workers seems a mistake. The wisdom and techniques of education and social work are essential, as are those of many other disciplines. Since no discipline has the answers to all PCC challenges, there should be a diversity in directors, professional staff, and consultants. Representatives of diverse disciplines, together with intended clients, have the best chance of designing and operationalizing workable models derived from their collective wisdom.

12. Cost Analysis. Experiences of the first year suggest two things, (1) that PCC directors need technical assistance in collecting and providing accurate cost data, and (2) that cost analysis for a PCC program is complicated by difficulties in defining outputs. The PCC Program was designed to provide inputs to families and communities which would meet basic human needs. The probable outcomes are like an iceberg; we can estimate a small percent of outputs, but we have good reason to believe that a large percent of the outputs will remain submerged and become apparent only in time. The May 1970 Kirschner Associates report of the community impacts of Head Start[1] was a good example of effects which were identified only recently. To quote a report by Dr. Lois Murphy (pg. 171, KAI report) a propos time and cost studies:

> We have lost sight of the fact that human beings are not part of the universe of machines, but are growing organisms who take their own time. To be sure, new forms of nutrition such as "Miracle-gro" tend to speed up the tempo of growth--but even so it is still true that radishes can be produced in a few weeks while it will still take a few years for wisteria to bloom; and Miracle-gro will not produce strawberries as fast as radishes. Moreover, while antibiotics may cure an illness quickly that is due to bacterial infection, virus infections have not yet been brought under such control and it is taking longer to discover the chemicals that will be able to effect these results.
>
> Inventions typically take time. Moreover, the payoff for many inventions cannot possibly be measured at early stages of the development of the invention. One impressive example is the fact that it took eight years for the Wright brothers to develop a primitive airborne machine that would stay off the ground for a period of 57 seconds. It could not be imagined at that time that within the lifetime of people who were children at the beginning stage, machines would be under development that would take people across the ocean in three hours.

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1. A National Survey of the Impacts of Head Start Centers on Community Institutions. Project Head Start, May 1970.

13. Evaluation and Research. A different evaluation of the PCC Program was planned for the second and third years when centers would be well underway. The suggested impacts of the PCC program's first year are such that evaluation should be broad rather than focused exclusively on the children. The first year experiences, particularly noted in the reports of research observers, suggest many important questions about the relationship between poverty and child development which merit careful research.

If evaluation or more basic research are to be worthwhile, it is recommended that data collection be done by people who are identified with the research enterprise, and who accept responsibility for careful recording of requisite information. The local Policy Advisory Committees are unlikely to support research for a number of reasons. One PAC member who reflects the sentiments of many parents, stated that she would not vote five cents to learn anymore about poverty.

14. Information Exchange. Centers need information from other centers, and each needs help in "packaging" its ideas and disseminating them. An information or dissemination officer, well acquainted with the media, and based in Washington would be helpful not only to centers but to everyone in the nation who is concerned with young children - and that's a large audience! PCC wisdom and materials will be especially welcomed by parents, and by teachers who are developing courses to prepare children and teens for more creative parenting.

15. Psychic Fatigue in the War on Poverty. In most poverty programs as in the PCC's, staff tend to experience greater personal stresses than in previous jobs. The nature of the job to be done, the enormity of the problems confronted, and the awareness that there are no quick solutions leads many workers to experience battle fatigue. This phenomenon is easily overlooked, treated by onlookers as malingering, and experienced with guilt by its victims. While a fascinating research problem in its own right, psychic fatigue is a reality which must not be ignored if PCC's are to accomplish their mission.

EPILOGUE

Before the Parent-Child Center became a reality, I was acquainted with the contents of Lifeline for Children, and the federal guidelines for PCC's. Then, as now, I was more convinced of the mission orientation of the PCC Program than of its research orientation. I liked the guidelines and I was particularly impressed with the comprehensiveness of the stated goals, the flexibility for local planning, and the insistence on client participation in writing the proposals (an idea less popular then than now). The PCC's represented a departure from traditional social and educational practice, and as such they constituted a brave new social experiment. They were new and different for at least three reasons: (1) they focused on the very young child who had not yet demonstrated a need for compensatory programs, (2) they involved parent participation in planning with professionals, and (3) they included a cross-institutional, multi-disciplinary matrix of services the likes of which had never been considered feasible.

Historically, PCC's grew out of an awareness that poor children lack many of the basic environmental supports and services which we have defined as essential in a civilized world. Politically, socially, medically, and in other contexts, the nation is turning to prevention as a more effective and economical alternative than remediation. Children whose life circumstances do not meet their basic needs must have sustained supplementary care throughout their developmental years if they are to acquire the human strengths necessary for functioning in a rapidly changing, complex society. We can never know the consequences of preventive programs, such as PCC's until we have tried them, given them our best talent and support, and waited for several years to witness the results. The risks are certainly smaller than if we do nothing!

Social innovations tend to court their own demise. The launching of 36 centers in locations chosen for reasons of political or administrative expediency guaranteed that PCC's would provide plenty of grist for criticism. Had there been a more modest beginning - a pilot year for PCC's - many families would be deprived of services they now enjoy. We would have gained the same insights and avoided challenges to the PCC program's feasibility as a national effort to optimize the development of high-risk children.

It is my view that the PCC's are teaching us a great deal in at least four major areas, as indicated below:

1. Innovative, multi-focus program ideas require new kinds of implementation and management skills to make them work. What are these skills: Which are most important? How do we prepare people for implementation roles? Certainly some PCC's will arrive at approximations if not answers.

2. There is very little known about what enhances the normal development of children under three years and the existing information is not readily communicated to child-care workers or parents. PCC's are accumulating a body of practical information derived from their day-to-day experiences which will undoubtedly enhance child-rearing practice and knowledge for all interested Americans.

3. Mothers who worked in PCC's have changed more than any other client group, and parents on Policy Advisory Committees have become identified with finding solutions to problems. These new models of parent participation in serving as well as being served, have opened doors to understanding adult growth and change and the conditions for their emergence. The PCC experience will undoubtedly suggest new social service concepts which may well revolutionize our previously held notions about the necessary and sufficient conditions for sustained individual and social change.

4. Families living in poverty demonstrate a remarkable variety of coping skills. We will undoubtedly learn from PCC families what it takes, humanly speaking, for adults to "stay alive" and to facilitate children's development under adverse circumstances. We'll also learn about those people who have died "in spirit" and who have nothing left to invest in their children's development. Is there such a process as immunization to prevent human deterioration? How elastic is the human person - is there a point at which his spirit is irrevocably broken? What do young children from families with different coping styles look like, and how readily do they respond to supplementary care? Certainly, PCC's will provide some of these answers.

In concluding, I submit that the Parent Child Center Program can be one of this nation's most significant contributions to the development of its future citizens. PCC's were launched from a limited knowledge base, but they are rapidly accumulating new knowledge and experience in facilitating the development of children. When the smoke clears, and programs have settled-down and been assessed, we shall probably recall the pioneering efforts of those early PCC's which succeeded in creating a gourmet's delight from a mixed bag of ingredients. Even more likely, we shall rediscover what we have always known, that children develop best when a variety of inter-locking systems in the society offer care and stimulation in the belief that children are its most valuable national resource.